RULES
OF
TENNESSEE DEPARTMENT OF HEALTH

CHAPTER 1200-13-10
DIVISION OF MEDICAID
HOSPICE PROGRAM

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1200-13-10-.01 DEFINITIONS. The following definitions shall apply to rules 1200-13-10-.02 through 1200-13-10-.05 inclusive, unless otherwise indicated.

(1) Attending physician - means a physician who is a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care

(2) Bereavement counseling - means services provided to the individual's family after the individual's death.

(3) Cap period - means the twelve-month period ending October 31 used in the application of the cap on overall hospice reimbursement as specified in 1200-13-10-.05(7) of these rules.

(4) Employee - means an employee (defined by section 210(j) of the Social Security Act, 42 U.S.C.A. section 410(j), as amended by Public Law 86-778, 1960) of the hospice or, if the hospice is a subdivision of a public agency or private organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. "Employee" also refers to a volunteer under the jurisdiction of the hospice.

(5) Representative - means a person who is, because of the recipient's mental or physical incapacity, authorized in accordance with State law to execute or revoke an election for hospice care or terminate medical care on behalf of a terminally ill individual who is mentally or physically incapacitated.

(6) Social worker - means a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education.

(7) Terminally ill - means that the individual has a medical prognosis that his or her life expectancy is six (6) months or less if the illness runs its normal course.

***Authority**: T.C.A. §§63-12-102, 63-12-l05, 63-12-106, 63-12-119, 63-12-124, 71-5-105, 71-5-109 and 4-5-202.* ***Administrative History**: Original rule filed June 12, 1991; effective July 27, 1991.*

1200-13-10-.02 ELIGIBILITY, ELECTION AND DURATION OF BENEFITS.

(1) Eligibility Requirements for Hospice Coverage

(a) Eligibility. In order to be eligible to elect hospice care under Medicaid, an individual must be -

1. Eligible to receive Medicaid benefits; and

2. Certified as being terminally ill in accordance with rule 1200-13-10-.02(3)(a).

(2) Election of Hospice Coverage

(a) Election statement. If an individual who meets the eligibility requirements for hospice care elects to receive that care, he or she must file an election statement with a particular hospice. An election may also be filed by a representative as defined in rule 1200-13-10-.01(7). The election statement must include the elements specified in rule 1200-13-10-.02(2)(f).

(b) Sequence of election periods:

1. An initial 90-day period.
2. A subsequent 90-day period.
3. A subsequent 30-day period.

(c) Duration of election. An election statement must be filed by an individual or representative for each elected benefit period.

(d) Effective date of election. An individual or representative may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care but may not designate an effective date that is earlier than the date that the election is made.

(e) Waiver of other benefits. An individual waives all rights to Medicaid payments for the duration of the election of hospice care for the following services.

1. Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).

2. Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services:

(i) Provided by the designated hospice;

(ii) Provided by another hospice under arrangements made by the designated hospice;

(iii) Provided by the individual's attending physician, which have a prior authorization, if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; and

(iv) Provided by specialty physicians for medical needs unrelated to the treatment of the terminal condition if those physicians are not employees of the designated hospice or receiving compensation from the hospice for those services. These services must be prior approved by Medicaid.

3. All other medical services and prescription drugs which have not been prior approved by Medicaid.

(f) Election statement: The election statement must include the following:

1. Identification of the particular hospice that will provide care to the individual.

2. The individual's or representatives acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness.

3. Acknowledgment that certain Medicaid services are waived by the election.

4. The effective date of the election.

5. The signature of the individual or representative.

(3) Obtaining certification.

(a) The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. For the first 90-day period of hospice coverage, the hospice obtains, no later than two (2) calendar days after hospice care is initiated, a written certification statement signed and dated by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individuals attending physician if the individual has an attending physician.

2. For the subsequent 90-day or 30-day period, the hospice obtains, no later than two calendar days after the beginning of that period, a written certification statement signed and dated by the medical director of the hospice or the physician member of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician.

3. A certification date may not be more than fourteen (14) days prior to the admit date of any benefit period.

(b) Certification statement - The certification must include:

1. The statement that the individual's medical prognosis is that his or her life expectancy is six (6) months or less if the terminal illness runs its normal course; and

2. The signature(s) of the physician(s) required to certify the terminal illness under 1200-13-10-.02(3) of this section.

(c) Maintaining a record. The hospice maintains the certification statements.

(4) Duration of Hospice Coverage

(a) An individual or representative may revoke the individual's election of hospice care at any time during an election period. Revocation of hospice coverage during an election period results in the forfeiture of the balance of days left in that period.

(b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:

1. A signed statement that the individual or representative revokes the individual's election for Medicaid coverage of hospice care for the remainder of that election period.

2. The date that the revocation is to be effective (An individual or representative may not designate an effective date earlier than the date that the revocation is made).

(c) An individual, upon revocation of the election of Medicaid coverage of hospice care for a particular election period:

1. Is no longer covered under Medicaid for hospice care;

2. Resumes Medicaid coverage of the benefits waived under rule 1200-13-10-.02(2)(e); and

3. May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.

(d) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not a revocation of the election for the period in which it is made. To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information.

1. The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care; and

2. The date the change is to be effective.

***Authority**: T.C.A. §§63-12-102, 63-12-105, 63-12-106, 63-12-119, 63-12-124, 71-5-105, 71-5-109 and 4-5-202.* ***Administrative History**: Original rule certified June 7, 1974; effective May 17, 1974. Amendment filed January 10, 1977, effective February 9, 1977. Amended filed March 13, 1978; effective April I2, 1978. Amendment filed May 7, 1979; effective June 21, 1979. Amendment filed October 28, 1981, effective December 14, 1981. Amendment filed June 12, 1991, effective July 27, 1991.*

1200-13-10-.03 CONDITIONS OF PARTICIPATION. In order to enroll and participate in the Medicaid Hospice Program, a hospice must comply with the following conditions of participation.

(1) Conditions of participation - General Provisions

(a) Standard: Qualifications. A hospice must be Medicare certified to participate in Medicaid's hospice program and comply with specific Medicaid quality assurance criteria which stipulates:

1. Each hospice must be audited annually to assure hospice services provided are medically necessary.

2. Plans of care are to be established and reviewed as specified in rule 1200-13-10-.03(5).

3. Care provided by home health aides must be audited and supervised by a registered nurse every fourteen (14) days.

(b) Standard: Compliance. A hospice must maintain compliance with the conditions described in rule 1200-13-10-.03(l) through 1200-13-10-.03(23). A hospice that provides inpatient services must also maintain compliance with the conditions in rule 1200-13-10-.03(24).

(c) Standard: Required services. A hospice must be primarily engaged in providing the care and services described in rule 1200-13-10-.04(2), must provide bereavement counseling and must -

1. Make nursing services, physician services, and drugs and biological routinely available on a twenty-four (24) hour basis;

2. Make all other covered services available on a twenty-four (24) hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions; and

3. Provide these services in a manner consistent with accepted standards of practice.

(d) Standard. Disclosure of information. The hospice must meet the disclosure of information requirements of 42 CFR Part 455, Subpart B (44 FR 41644, July 17, 1979, as amended at 51 FR 34788, September 30, 1986).

(2) Condition of participation - Governing body.

A hospice must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing body must designate an individual who is responsible for the day-to-day management of the hospice program. The governing body must also ensure that all services provided are consistent with accepted standards of practice.

(3) Condition of participation - Medical director.

The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.

(4) Condition of participation - Professional management.

Subject to the conditions of participation pertaining to services in rule 1200-13-10-.03(13) and rule 1200-13-10-.03(19), a hospice may arrange for another individual or entity to furnish services to the hospice's patient. If services are provided under arrangement, the hospice must meet the following standards:

(a) Standard: Continuity of care. The hospice program assures the continuity of patient/family care in home, outpatient, and inpatient

(b) Standard: Written agreement. The hospice has a legally binding written agreement for the provision of arranged services. The agreement includes at least the following:

1. Identification of the services to be provided.

2. A stipulation that services may be provided only with the express authorization of the hospice.

3. The manner in which the contracted services are coordinated, supervised, and evaluated by the hospice.

4. The delineation of the role(s) of the hospice and the contractor in the admission process, patient/family assessment, and the interdisciplinary group care conferences.

5. Requirement for documenting that services are furnished in accordance with the agreement.

6. The qualifications of the personnel providing the services.

(c) Standard: Professional management responsibility. The hospice retains professional management responsibility for those services and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications of this part, and in accordance with the patient's plan of care and the other requirements of this part.

(d) Standard: Financial responsibility. The hospice retains responsibility for payment for services.

(e) Standard: Inpatient care. The hospice ensures that inpatient care is furnished only in a facility which meets the requirements in rule 1200-13-10-.03(23) and its arrangement for inpatient care is described in a legally binding written agreement that meets the requirements of subparagraph (b) above and that also specifies, at a minimum:

1. That the hospice furnishes to the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;

2. That the inpatient provider has established policies consistent with those of the hospice and agrees to abide by the patient care protocols established by the hospice for its patients;

3. That the medical record includes a record of all inpatient services and events and that a copy of the discharge summary and, if requested, a copy of the medical record are provided to the hospice;

4. The party responsible for the implementation of the provisions of the agreement; and

5. That the hospice retains responsibility for appropriate hospice care training of the personnel who provide the care under the agreement.

(5) Condition of participation - Plan of care.

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

(a) Standard. Establishment of the plan of care. The plan of care must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

(b) Standard: Review of the plan of care. The plan of care must be reviewed and updated every fourteen (14) days, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented.

(c) Standard: Content of the plan of care. The plan of care must include an assessment of the individual's needs and identification of the services to be provided including those for the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(6) Condition of participation - Informed consent.

A hospice must demonstrate respect for an individuals rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the individual or representative as defined in rule 1200-13-l0-.01.

(7) Condition of participation - Inservice training.

A hospice must provide an ongoing program for the training of its employees.

(8) Condition of participation - Quality assurance.

A hospice must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided, including inpatient care, home care and care provided under arrangements. The findings are used by the hospice to correct identified problems and to revise hospice policies if necessary. Those responsible for the quality assurance program must:

(a) Implement and report on activities and mechanisms for monitoring the quality of patient care;

(b) Identify and resolve problems; and

(c) Make suggestions for improving patient care.

(9) Condition of participation - Interdisciplinary group.

The hospice must designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice.

(a) Standard: Composition of group. The hospice must have an interdisciplinary group or groups that include at least the following individuals who are employees of the hospice:

1. A doctor of medicine or osteopathy.

2. A registered nurse.

3. A social worker.

4. A pastoral or other counselor.

(b) Standard: Role of group. The interdisciplinary group is responsible for:

1. Participation in the establishment of the plan of care;

2. Provision or supervision of hospice care and services;

3. Periodic review and update of the plan of care for each individual receiving hospice care; and

4. Establishment of policies governing the day-to-day provision of hospice care and services. If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute this function.

(c) Standard: Coordinator. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

(10) Condition of participation - Volunteers.

The hospice in accordance with the numerical standards specified in rule 1200-13-10-.03(10)(e) uses volunteers, in defined roles, under the supervision of a designated hospice employee.

(a) Standard: Training. The hospice must provide appropriate orientation and training that is consistent with acceptable standards of hospice practice.

(b) Standard: Role. Volunteers must be used in administrative or direct patient care roles.

(c) Standard: Recruiting and retaining. The hospice must document active and ongoing efforts to recruit and retain volunteers.

(d) Standard: Cost saving. The hospice must document the cost savings achieved through the use of volunteers. Documentation must include:

1. The identification of necessary positions which are occupied by volunteers;

2. The work time spent by volunteers occupying those positions; and

3. Estimates of the dollar costs which the hospice would have incurred if paid employees occupied the positions identified in part (d)(1) for the amount of time specified in part (d)(2) of this paragraph.

(e) Standard: Level of activity. A hospice must document and maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals five percent (5%) of the total patient care hours of all paid hospice employees and contract staff. The hospice must document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services and the time worked, must be recorded.

(f) Standard: Availability of clergy. The hospice must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to patients who request such visits and must advise patients of this opportunity.

(11) Condition of participation - Licensure.

The hospice and all hospice employees must be licensed in accordance with applicable Federal, State and local laws and regulations.

(a) Standard: Licensure program. If State or local law provides for licensing of hospice, the hospice must be licensed.

(b) Standard: Licensure of employee. Employees who provide services must be licensed, certified or registered in accordance with applicable Federal or State laws.

(12) Condition of participation - Central clinical records.

In accordance with accepted principles of practice, the hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

(a) Standard: Content. Each clinical record is a comprehensive compilation of information. Entries are made for all services provided. Entries are made and signed by the person providing the services. The record includes all services whether furnished directly or under arrangement made by the hospice. Each individual's record contains.

1. The initial and subsequent assessments;

2. The plan of care;

3. Identification data;

4. Consent and authorization and election forms;

5. Pertinent medical history; and

6. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

(b) Standard: Protection of information. The hospice must safeguard the clinical record against loss, destruction and unauthorized use.

(13) Condition of participation - Core services.

Except as permitted in rule 1200-13-10-.03(15), a hospice must ensure that substantially all the core services described in rule 1200-13-10-.03(14) through 1200-13-10-.03(18) are routinely provided by hospice employees. A hospice may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial and administrative responsibility for the services and must assure that the qualifications of staff and services provided meet the requirements specified in rule 1200-13-10-.03(14) through 1200-13-10-.03(18).

(14) Condition of participation - Nursing services.

The hospice must provide nursing care and services by or under the supervision of a registered nurse.

(a) Nursing services must be directed and staffed to assure that the nursing needs of patients are met.

(b) Patient care responsibilities of nursing personnel must be specified.

(c) Nursing services must be provided in accordance with recognized standards of practice.

(15) Nursing services - Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.

(a) The Health Care Financing Administration, U.S. Department of Health and Human Services (HCFA) may approve a waiver of the requirements in rule 1200-13-10-.03(13) for nursing services provided by a hospice which is located in a non-urbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence that it was operational on or before January 1, 1983, and that it made a good faith effort to hire a sufficient number of nurses to provide services directly. HCFA bases its decision as to whether to approve a waiver application on the following:

1. The current Bureau of the Census designations for determining non-urbanized areas.

2. Evidence that a hospice was operational on or before January 1, 1983 including:

(i) Proof that the organization was established to provide hospice services on or before January 1, 1983;

(ii) Evidence that hospice-type services were furnished to patients on or before January 1, 1983; and

(iii) Evidence that the hospice care was a discrete activity rather than an aspect of another type of provider's patient care program on or before January 1, 1983.

3. Evidence that a hospice made a good faith effort to hire nurses, including:

(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts;

(ii) Job descriptions for nurse employees;

(iii) Evidence that salary and benefits are competitive for the area; and

(iv) Evidence of any other recruiting activities (e.g., recruiting efforts at health fairs and contacts with nurses at other providers in the area; and

(b) Any waiver request is deemed to be granted unless it is denied within (60) days after it is received by HCFA.

(c) Waiver will remain effective for one (1) year at a time.

(d) HCFA may approve a maximum of two (2) one-year extensions for each initial waiver. If a hospice wishes to receive a one (1) year extension, the hospice must submit a certification to HCFA, prior to the expiration of the waiver period, that the employment market for nurses has not changed significantly since the time the initial waiver was granted.

(e) All waiver requests must be made directly to HCFA pursuant to rule 1200-13-10-.03(15)(a).

(16) Condition of participation - Medical social services.

Medical social services must be provided by a qualified social worker, under the direction of a physician.

(17) Condition of participation - Physician services.

In addition to palliation and management of terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician.

(18) Condition of participation - Counseling services.

Counseling services must be available to both the individual and the family. Counseling includes bereavement counseling, provided after the patient's death as well as dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice.

(a) Standard: Bereavement counseling. There must be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one (1) year following the death of the patient). A. special coverage provision for bereavement counseling is specified in rule 1200-13-10-.04(3).

(b) Standard: Dietary counseling. Dietary counseling, when required, must be provided by a registered dietitian.

(c) Standard: Spiritual counseling. Spiritual counseling must include notice to patients as to the availability of clergy as provided in rule 1200-13-10-.03(10)(f).

(d) Standard: Additional counseling. Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.

(19) Condition of participation - Other services.

A hospice must ensure that the services described in rule 1200-13-10-.03(20) to rule 1200-13-10-.03(23) are provided directly by hospice employees or under arrangements made by the hospice as specified in rule 1200-13-10-.03(4).

(20) Condition of participation - Physical therapy, occupational therapy, and speech-language pathology.

Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.

(21) Condition of participation - Home health aide and homemaker services.

Home health aide and homemaker services must be available and adequate in frequency to meet the needs of the patients. A home health aide is a person who meets the training, attitude and skill requirements specified in 42 CFR 484.36 (54 FR 33367, August 14, 1989).

(a) Standard: Supervision. A registered nurse must visit the home site at least every two (2) weeks when aide services are being provided, and the visit must include an assessment of the aide services.

(b) Standard: Duties. Written instructions for patient care are prepared by a registered nurse. Duties include, but may not be limited to, the duties specified in 42 CFR 484.36(c) (54 FR 33367, August 14, 1989).

(22) Condition of participation - Medical supplies.

Medical supplies and appliances including drugs and biologicals, must be provided as needed for the palliation and management of the terminal illness and related conditions.

(a) Standard: Administration. All drugs and biologicals must be administered in accordance with accepted standards of practice.

(b) Standard: Controlled drugs in the patient's home. The hospice must have a policy for the disposal of controlled drugs maintained in the patient's home when those drugs are no longer needed by the patient.

(c) Standard: Administration of drugs and biologicals. Drugs and biologicals are administered only by the following individuals:

1. A licensed nurse or physician.

2. An employee who has completed a State-approved training program in medication administration.

3. The patient if his or her attending physician has approved.

4. Any other individual in accordance with applicable State and local laws. The persons, and each drug and biological they are authorized to administer, must be specified in the patient's plan of care.

(23) Condition of participation - Short-term inpatient care.

Inpatient care must be available for pain control, symptom management and respite purposes, and must be provided in a participating Medicare facility.

(a) Standard: Inpatient care for symptom control. Inpatient care for pain control and symptom management must be provided in one of the following:

1. A hospice that meets the condition of participation for providing inpatient care directly as specified in rule 1200-13-10-.03(24).

2. A hospital or a Level 2 NF (reference 1200-13-1-.05(15)) that also meets the standards specified in rule 1200-13-10-.03(24)(a) and 1200-13-10-.03(24)(f) regarding twenty-four (24) hour nursing service and patient care.

(b) Standard: Inpatient care for respite purposes. Inpatient care for respite purposes must be provided by one of the following:

1. A provider specified in subparagraph (a) above of this paragraph.

2. A Level 1 NF (reference 1200-13-1-.05(15)) that also meets the standards specified in rule 1200-13-1-.03(24)(a) and 1200-13-10-.03(24)(f) regarding twenty-four (24) hour nursing service and patient care.

(c) Standard: Inpatient care limitation. The total number of inpatient days used by Medicaid recipients who elected hospice coverage in any twelve (12) month period preceding a certification survey in a particular hospice may not exceed twenty (20) percent of the total number of hospice days for this group of recipients.

(24) Condition of participation for hospice providing inpatient care directly.

A hospice that provides inpatient care directly must comply with all of the following standards.

(a) Standard: Twenty four (24) hour nursing services.

1. The facility provides twenty-four (24) hour services which are sufficient to meet total nursing needs and which are in accordance with the patient plan of care. Each patient receives treatment, medications, and diet as prescribed, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

2. Each shift must include a registered nurse who provides direct patient care.

(b) Standard: Disaster preparedness. The hospice has an acceptable written plan periodically rehearsed with staff, with procedures to be followed in the event of an internal or external disaster for the care of casualties (patients and personnel) arising from such disasters.

(c) Standard: Health and safety laws. The hospice must meet all Federal, State, and local laws, regulations, and codes pertaining to health and safety, such as provisions regulating:

1. Construction, maintenance, and equipment for the hospice;

2. Sanitation;

3. Communicable and reportable diseases; and

4. Post mortem procedures.

(d) Standard: Fire protection

1. Except as provided in parts (d)2. and (d)3. of this subparagraph, the hospice must meet the provisions of the 1985 edition of the Life Safety Code of the National Fire Protection (which is incorporated by reference) that are applicable to hospices.

2. In consideration of a recommendation by the State survey agency, HCFA may waive for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied would result in unreasonable hardship for the hospice, but only if the waiver would not adversely affect the health and safety of the patients.

3. Any hospice that, on May 9, 1988, complies with the requirements of the 1981 edition of the Life Safety Code, with or without waivers, will be considered to be in compliance with this standard, as long as the hospice continues to remain in compliance with that edition of the Life Safety Code.

4. Any facility of two or more stories that is not of fire resistive construction and is participating on the basis of a waiver of construction type or height, may not house blind, non-ambulatory, or physically handicapped patients above the street-level floor unless the facility -

(i) Is one of the following construction types (as defined in the Lift Safety Code):

(I) Type II (1, 1, 1) - protected non-combustible;

(II) Fully sprinklered Type II (0, 0, 0) - non-combustible;

(III) Fully sprinklered Type III (2, 1, 1) - protected ordinary;

(IV) Fully sprinklered Type V (1, 1, 1) - protected wood frame; or

(ii) Achieves a passing score on the Fire Safety Evaluation System (FSES).

(e) Standard: Patient areas.

1. The hospice must design and equip areas for the comfort and privacy of each patient and family members.

2. The hospice must have:

(i) Physical space for private patient/family visiting;

(ii) Accommodations for family members to remain with the patient throughout the night;

(iii) Accommodations for family privacy after a patient's death; and

(iv) Decor which is homelike in design and function.

3. Patients must be permitted to receive visitors at any hour, including small children.

(f) Standard: Patient rooms and toilet facilities. Patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients.

1. Each patient's room must:

(i) Be equipped with or conveniently located near toilet and bathing facilities,

(ii) Be at or above ground level;

(iii) Contain a suitable bed for each patient and other appropriate furniture;

(iv) Have closet space that provides security and privacy for clothing and personal belongings;

(v) Contain no more than four beds;

(vi) Measure at least one hundred (100) square feet for a single patient room or eighty (80) square feet for each patient for a multipatient room; and

(vii) Be equipped with a device for calling the staff member on duty.

2. For an existing building, HCFA may waive the space and occupancy requirements of subparagraphs (f)l.(v) and (vi) of this paragraph for as long as it is considered appropriate if it finds that:

(i) The requirements would result in unreasonable hardship on the hospice if strictly enforced; and

(ii) The waiver serves the particular needs of the patients and does not adversely affect their health and safety.

(g) Standard: Bathroom facilities. The hospice must:

1. Provide an adequate supply of hot water at all times for patient use; and

2. Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.

(h) Standard: Linen. The hospice has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(i) Standard: Isolation areas. The hospice must make provision for isolating patients with infectious diseases.

(j) Standard: Meal service, menu planning, and supervision. The hospice must:

1. Serve at least three (3) meals or their equivalent each day at regular times, with not more than fourteen (14) hours between a substantial evening meal and breakfast;

2. Procure, store, prepare, distribute, and serve all food under sanitary conditions;

3. Have a registered dietitian on staff trained or experienced in food management or nutrition who is responsible for:

(i) Planning menus that meet the nutritional needs of each patient, following the orders of the patient's physician and, to the extent medically possible, the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Science (Recommended Dietary Allowances (9th ed, 1981) is available from the Printing and Publications Office, National Academy of Sciences, Washington, D.C. 20418); and

(ii) Supervising the meal preparation and service to ensure that the menu plan is followed.

4. If the hospice has patients who require medically prescribed special diets, have the menus for those patients planned by a registered dietitian who supervises the preparation and serving of meals to ensure that the patient accepts the special diet.

(k) Standard: Pharmaceutical services. The hospice provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is responsible for drugs and biologicals for its patients, insofar as they are covered under the program and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State, and local laws.

1. Licensed pharmacist. The hospice must:

(i) Employ a licensed pharmacist; or

(ii) Have a formal agreement with a licensed pharmacist to advise the hospice on ordering, storage, administration, disposal, and recordkeeping of drugs and biologicals.

2. Orders for medications.

(i) A physician must order all medications for the patient.

(ii) If the medication order is verbal:

(I) The physician must give it only to a licensed nurse, pharmacist, or another physician; and

(II) The individual receiving the order must record and sign it immediately and have the prescribing physician sign it in a manner consistent with good medical practice.

3. Administering medication. Medications are administered only by one of the following individuals:

(i) A licensed nurse or physician.

(ii) An employee who has completed a State-approved training program in medication administration.

(iii) The patient if his or her attending physician has approved.

4. Control and accountability. The pharmaceutical service has procedures for control and accountability of all drugs and biologicals through the facility. Drugs are dispensed in compliance with Federal and State laws. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation. The pharmacist determines that drug records are in order and that an account of all controlled drugs is maintained and reconciled.

5. Labeling of drugs and biologicals. The labeling of drugs and biologicals is based on currently accepted professional principles, and includes the appropriate accessory and cautionary instructions, as well as the expiration date when applicable.

6. Storage. In accordance with State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Separately locked compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. An emergency medication kit is kept readily available.

7. Drug disposal. Controlled drugs no longer needed by the patient are disposed of in compliance with State requirements. In the absence of State requirements the pharmacist and a registered nurse disposed of the drugs and prepare a record of the disposal

***Authority**: T.C.A. §§63-12-102, 63-12-105, 63-12-106, 63-12-119, 63-12-124, 71-5-105, 71-5-109 and 4-5-202.* ***Administrative History**: Original rule certified June 7, 1974; effective May 17, 1974. Repeal filed February 5, 1979; effective March 21, 1979. Amendment filed June 12, 1991, effective July 27, 1991.*

1200-13-10-.04 COVERED SERVICES.

(1) Requirements for coverage.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The individual must elect hospice care in accordance with rule 1200-13-10-.02(2) and plan of care must be established as set forth in rule 1200-13-10-.03(5) before services are provided. The services must be consistent with the plan of care. A certification that the individual is terminally ill must be completed as set forth in rule 1200-13-10-.02.

(2) Covered services.

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

(a) Nursing care provided by or under the supervision of a registered nurse.

(b) Medical social services provided by a social worker under the direction of a physician.

(c) Physicians' services performed by a physician as defined in 42 CFR 410.20 (as amended at 51 FR 41339, November 14, 1986) and governed by State regulations except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.

(d) Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

(e) Short-term inpatient care provided in participating hospice inpatient unit, or a participating hospital or Level 2 NF that additionally meets the standards in rule 1200-13-10-.03(24)(a) and 1200-13-10-.03(23)(f) regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management.

Inpatient care may also be furnished as a means of providing respite for the individual's family or other persons caring for the individual at home. Respite care must be furnished as specified in rule 1200-13-10-.03(23)(b). Payment for inpatient care will be made at the rate appropriate to the level of care as specified in rule 1200-13-10-.05(2).

(f) Medical appliances and supplies, including drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.

(g) Home health aide services furnished by qualified aides as designated in rule 1200-13-10-.03(21) and homemaker services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan.

(h) Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.

(3) Special coverage requirements.

(a) Periods of crisis. Nursing care may be covered on a continuous basis for as much as twenty-four (24) hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide services or both may be covered on a twenty-four (24) hour continuous basis during periods of crisis but care during these periods must be predominately nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

(b) Respite care.

1. Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.

2. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days at a time.

(c) Bereavement counseling. Bereavement counseling is a required hospice service but it is not reimbursable.

Authority:. *T.C.A. 71-5-105, 71-5-109 and 4-5-202.* ***Administrative History:*** *Original rule filed June 12, 1991; effective July 27, 1991.*

1200-13-10-.05 REIMBURSEMENT METHODS.

(1) Reimbursement of hospice care.

(a) Medicaid payment for hospice care is made in accordance with the method set forth in rule 1200-13-10-.05(2) and 42 CFR 418.302 (48 FR 56026, December 16, 1983).

(b) Medicaid reimbursement to a hospice in a cap period is limited to a cap amount specified in rule 1200-13-10-.05(7) and 42 CFR 418.309 (48 FR 56026, December 16, 1983).

(2) Payment procedures for hospice care.

(a) HCFA establishes payment amounts to reimburse specific categories of covered hospice care.

(b) Payment amounts are determined within each of the following categories:

1. Routine home care day. A routine home care day is a day on which an individual who has to receive hospice care is at home and is not receiving continuous care as defined in rule 1200-13-10-.05(2)(b)2.

2. Continuous home care day. A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility and received hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in rule 1200-13-10-.04(3)(a) and only as necessary to maintain the terminally ill patient at home.

3. Inpatient respite care day. An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite.

4. General inpatient care day. A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

(c) The payment amounts for the categories of hospice care are fixed payment rates that are calculated by HCFA in accordance with the procedures described in rule 1200-13-10-.05(4). Payment rates are determined for the following categories:

1. Routine home care.
2. Continuous home care.
3. Inpatient respite care.
4. General inpatient care.

(d) Reimbursement will be made to the hospice at the appropriate payment amount for each day for which an eligible Medicaid recipient is under the hospices care.

(e) Reimbursement will be made according to the following procedures:

1. Payment is made to the hospice for each day during which the recipient is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day.

2. Payment is made for only one of the categories of hospice care described in rule 1200-13-10-.05(2)(b) for any particular day.

3. On any day of which the recipient is not an inpatient, the hospice is paid the routine home care rate, unless the patient receives continuous care as defined in rule 1200-13-10-.05(2)(b)2. for a period of at least eight (8) hours. In that case, a portion of the continuous care day rate is paid in accordance with rule 1200-13-10-.05(2)(e)4.

4. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous home care rate is divided by twenty-four (24) to yield an hourly rate. The number of hours of continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of eight (8) hours of care must be furnished on a particular day to qualify for the continuous home care rate.

5. Subject to the limitations described in rule 1200-13-10-.05(2)(f), on any day on which the recipient is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care furnished. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the recipient is discharged deceased, the inpatient rate (general or respite) is paid for the discharge day. Payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than five (5) days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.

(f) Payment for inpatient care is limited as follows:

1. The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid patients not exceed twenty percent (20%) of the total days for which these patients had elected hospice care.

2. At the end of a cap period, Medicaid will calculate a limitation on payment for inpatient care (general or respite) to ensure payment is not made in excess of twenty percent (20%) of the total number of days of hospice care furnished to Medicaid patients.

3. If the number of days of inpatient care furnished to Medicaid patients is equal to or less than twenty percent (20%) of the total days of hospice care to Medicaid patients, no adjustment is necessary. Overall payments to a hospice are subject to the cap amount specified in rule 1200-13-10-.05(7).

4. If the number of days of inpatient care furnished to Medicaid patients exceeds twenty percent (20%) of the total days of hospice care to Medicaid patients, the total payment for inpatient care is determined in accordance with the procedures specified in rule 1200-13-10-.05(2)(f)5. That amount as compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the hospice. Overall payments to the hospice are subject to the cap amount specified in rule 1200-13-10-.05(7).

5. If the hospice exceeds the number of inpatient care days described in rule 1200-13-10-.05(2)(f)4., the total payment for inpatient care is determined as follows:

(i) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicaid patients;

(ii) Multiply this ratio by the total reimbursement for inpatient care made by Medicaid;

(iii) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate; and

(iv) Add the amounts calculated in rule 1200-13-10-.05(2)(f)5.(ii) and 1200-13-10-.05(2)(f)5.(iii).

(3) Payment for physician services.

(a) The following services performed by hospice physicians are included in the rates described in rule 1200-13-10-.05(2):

1. General supervisory services of the medical director.

2. Participation in the establishment of plans of care, supervision of care and services, periodic review and update of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

(b) For services not described above in rule 1200-13-10-.05(3)(a) payment will be made to the hospice in an amount equivalent to one hundred percent (100%) of the physicians reasonable charge as allowed by Medicare for those physician services furnished by hospice employees under arrangements with the hospice subject to a cap. Reimbursement for these physician services is included in the amount subject to the hospice payment limit described in rule 1200-13-10-.05(7). Services furnished voluntarily by physicians are not reimbursable.

(c) Services of the patient’s attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice which have a prior authorization, related to the patient's terminal illness will be reimbursed an amount equivalent to one hundred percent (100%) of the physicians reasonable charge as allowed by Medicare.

(d) Specialty physician services that are not related to the patient's terminal illness must be prior approved by Medicaid and will be reimbursed in accordance with rule 1200-13-1-.06(9) and are subject to service limitations specified in rule 1200-13-1-.03(l)(g).

(4) Determination of payment rates.

(a) Payment rates will be calculated for each of the categories of hospice care described in rule 1200-13-10-.05(2)(c).

(b) Each rate is equal to a prospectively determined amount which is estimated to equal the costs incurred by a hospice efficiently providing that type of hospice care to Medicaid recipients.

(c) The rates are adjusted to reflect local differences in wages.

(d) Medicaid will publish notice in the *Tennessee Administrative Register (TAR)* of any proposal to change the payment rates or the methodology for determining those rates.

(5) Periodic interim payments.

Hospice agencies may elect to receive periodic interim payments or may submit claims at the termination of service to the patient.

(6) Limitation on the amount of hospice payments.

(a) Except as specified in rule 1200-13-10-.05(6)(b) below, the total Medicaid payment to a hospice for care furnished during a cap period is limited by the hospice cap amount specified rule 1200-13-10-.05(7).

(b) Medicaid shall notify the hospice of the determination of program reimbursement at the end of the cap year in accordance with procedures similar to those described in 42 CFR 405.1803 (48 FR 39834; 51 FR 34793, September 30, 1986).

(c) Payments made to a hospice during a cap period that exceed the cap amount are overpayments and must be refunded to the Medicaid Program.

(7) Hospice cap amount.

The hospice cap amount is calculated using the following procedures:

(a) The cap amount is $6,500 per year and is adjusted for inflation or deflation for cap years that end after October 1, 1984, by using the percentage change in the medical care expenditure category of the Consumer Price Index (CPI) for urban consumers that is published by the Bureau of Labor Statistics. This adjustment is made using the change in the CPI from March 1984 to the fifth month of the cap year. The cap year runs from November 1 of each year until October 31 of the following year. Beginning with care and services furnished after December 31, 1989, payment amounts will be increased by twenty percent (20%) for the 1989/90 cap year and thereafter will be increased according to the percentage increase allowed by Medicare.

(b) Each hospices' cap amount is calculated by multiplying the adjusted cap amount determined in rule 1200-13-10-.05(7)(a) above by the number of Medicaid recipients who elected to receive hospice care from that hospice during the cap period. For purposes of this calculation, the number of Medicaid recipients includes:

1. Those who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care, in accordance with rule 1200-13-10-.02, from the hospice during the period beginning on

September 28 (thirty-five (35) days before the beginning of the cap period) and ending on September 27 (thirty-five (35) days before the end of the cap period).

2. In the case in which a recipient has elected to receive care from more than one (1) hospice, each hospice includes in its number of Medicaid recipients only that fraction which represents the portion of a patient's total stay in all hospices that was spent in that hospice.

(8) Reporting and recordkeeping requirements.

Hospices must provide reports and keep records as necessary to administer the program.

Authority: *T.C.A. §§71-5-105, 71-5-109 and 4-5-202.* ***Administrative History:*** *Original rule filed June 12, 1991; effective July 27, 1991.*

1200-13-10-.06 TERMINATION OF HOSPICE PROGRAM RULES. For hospice services provided prior to January 1, 1994, the hospice rules as set out at rule chapter 1200-13-10 shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except that Tennessee Medicaid will continue to pay Medicare premiums, deductible and copayments in accordance with the Medicaid rules in effect prior to January 1, 1994, and as may be amended.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Public Chapter 358 of the Acts of 1993.* ***Administrative History****: Original rule filed March 18, 1994; effective June 1, 1994.*